Mississippi Transitional Refresher Course
History Taking Course Outline

Minimum course length 16 hours

1. History Taking

    A. Refers to information gathered during a patient interview

    1. Provides an account of:

        1. Medical and social occurrences in a patient's life
        2. Environmental factors that may have a bearing on the patient's condition

2. Components of a Patient History

    1. Date and time

        1. Identifying data
        2. Source of referral
        3. Source of history

    2. Chief complaint

        1. Present illness
        2. Past history
        3. Current health status
        4. Review of body systems

3. Techniques of History Taking

    1. Setting the Stage

        1. The environment
        2. Your demeanor and appearance
        3. Note taking

    2. Learning about the Present Illness

        1. Greeting the patient
            1. Greet the patient by name
            2. Shake hands
            3. Avoid the use of unfamiliar or demeaning terms

2. The patient's comfort
    1. Be alert to patient comfort levels
    2. Ask about the patient's feelings
    3. Watch for signs of uneasiness

3. Opening Questions

    1. Find out why the patient is seeking medical care or advice
    2. Use a general, open-ended question
    3. Follow the patient's leads

4. Therapeutic Communication

    1. Facilitation
    2. Reflection
    3. Clarification
    4. Empathy
    5. Confrontation
    6. Interpretation

4. Chief Complaint

    1. The one or more symptoms for which the patient is seeking medical care

    2. Most chief complaints are characterized by:

        1. Pain
        2. Abnormal function
        3. A change in the patient's normal state
        4. An unusual observation made by the patient (e.g., heart palpitations)

    3. Be alert to the possibility that a chief complaint may be misleading or that a problem may be more serious than the patient's chief complaint

5. History of Present Illness (HPI)

    1. Identifies the chief complaint and provides a full, clear, chronological account of the symptoms

    2. A thorough HPI requires skill in:

        1. Asking appropriate questions related to the chief complaint
        2. Interpreting the patient's response to those questions

    3. OPQRST

1. Onset of problem
2. Provocation/palliative
3. Quality
4. Region/radiation/referral
5. Severity
6. Time

4. Pertinent positives and negatives

    1. Pertinent positives ─ findings verified by the history or physical examination

    2. Pertinent negatives ─ findings not verified by the history or physical examination

6. Medical History

    1. General state of health

        1. Childhood illnesses
        2. Adult illnesses
        3. Accidents and injuries
        4. Surgeries or hospitalizations

    2. Psychiatric illnesses

    3. Current Health Status

        1. Allergies
            1. Medication allergies
            2. Food allergies
            3. Environmental allergies
            4. Look for medical identification devices

        2. Medications

            1. Ask if the patient takes any medications regularly and if so why
            2. Determine medication compliance
            3. Ask about nonprescription medications
            4. Ask about nonprescribed drugs for recreational purposes

        3. Past Medical history

            1. Personal history
            2. Family medical history

4. Last Oral Intake

    1. May affect potential airway problems if the patient loses consciousness

    2. May help determine the appropriateness of surgery

    3. May help rule out other problems

5. Last Menstrual Period if Female

    1. Important for women with abdominal pain

    2. Patient's response should determine the need to pursue additional questions regarding:

        (1) Contraceptive use
        (2) Venereal disease
        (3) Urinary tract infections
        (4) Ectopic pregnancy

6. Last Bowel Movement

    1. Determine if normal or abnormal for patient

        (1) Obtain related history
            (1) Diarrhea
            (2) Constipation
            (3) Bloody bowel movements

    2. Discuss abnormal urinary function

        (1) Hematuria
        (2) Urethral discharge
        (3) Pain or burning with urination
        (4) Frequent urination
        (5) Inability to void

4. Events Before the Emergency

    1. May be obtained from the patient and/or bystanders

    2. Attempt to correlate any event with the beginning or progression of an illness or injury

5. Environmental Conditions

6. Home conditions

7. Occupation

8. Travel

    1. Exposure to contagious diseases
    2. Military record
    3. Geographical areas
    4. Exposure to chemicals

7. Patient History

1. Personal habits

    1. Tobacco use
    2. Alcohol, other drugs, and related substances

2. Diet

    1. Normal daily intake of food and beverages
    2. Consumption of stimulants
    3. Special diet
    4. Appetite

3. Tests/immunizations

    1. Screening tests
    2. Immunizations

4. Sleep patterns

    1. Exercise and leisure activities

    2. Environmental hazards

    3. Additional information

        1. Home situation, spouse, or significant other
        2. Daily life
        3. Important experiences
        4. Religious beliefs
        5. Patient outlook

8. Questioning Technique: To gather additional information, direct questions may be

required

1. Do not ask leading questions
2. Ask one question at a time
3. Use language that is appropriate

9. Sensitive Topics:

    1. Alcohol and drugs

        1. CAGE questionnaire may be a useful tool when evaluating a patient's use of alcohol

        2. CAGE is an acronym for:

            1. Cutting down - Have you ever felt the need to Cut down on your drinking?

            2. Annoyance by criticism - Have you ever felt Annoyed by criticism of your drinking?

            3. Guilty feeling - Have you ever felt Guilty about your drinking?

            4. Eye-openers - Have you ever felt the need for a morning Eye-opener?

    2. Physical Abuse or Violence

        1. The battered patient

            1. Clues about the situation
            2. Direct questioning is best

        2. Remember the following key points:

            1. Demonstrate a nonjudgmental attitude
            2. Avoid judgmental statements
            3. Avoid "why" questions
            4. Demonstrate a supportive attitude

    3. Sexual History

        1. Questions regarding the patient's sexual history may be embarrassing for the paramedic and patient - Keep questions "gender neutral"

    4. Special Challenges

1. Silence
2. Over-talkative patients

3. Patients with multiple symptoms

4. Anxious patients

    1. Providing false reassurance may be tempting

    2. Avoid early reassurance or “over reassurance” until it can be provided with confidence

5. Anger and hostility

6. Intoxication

7. Crying

8. Depression

9. Sexually attractive or seductive patients

10. Confusing behavior or histories

11. Limited intelligence

10. Communication Barriers

    1. Barriers in communication may result from:

        1. Social or cultural differences
        2. Sight, speech, or hearing impairments

    2. Attempt to find assistance to aid in communication

11. Talking with Family and Friends

    1. Friends and family are often at the scene of an emergency

        1. They should be considered a good source of information

        2. They are often helpful when the patient cannot provide all necessary information due to illness or injury

    2. If not available and additional patient information is needed, try to locate a third party who can help supply missing data

12. Summary